Pathways Radiology PA Form

State of Maine Department of Health and Human Services

____ MEDICALLY URGENT

_____New PA Request _____Update PA Request* _____PA Supporting Documentation only*

Electronic PA# _____

*If **'Update PA Request'** or **'PA Supporting Documentation only'** is selected, the Electronic PA# is required.

PLEASE USE BLACK OR BLUE INK, OR COMPLETE ELECTRONICALLY
PHONE: 1-866-690-5585 FAX: 1-866-598-3963

Fax Date: _____ Submitter Name: _____

Submitter Telephone #: _____Submitter Fax #_____

Patient Name: ☐ M ☐ F		**DOB:**	
Medicaid ID# (not Medicare):	__ __ __ __ __ __ __ __ __		
Requesting Provider Information			
Name:	**NPI#:** __ __ __ __ __ __ __ __ __ __	**Group NPI#:** __ __ __ __ __ __ __ __ __ __	
Requesting Provider Office Address 1:			
Requesting Provider Office Address 2:		City:	Zip:
		Phone:	Fax:
Servicing Provider	Name:	**NPI#:** __ __ __ __ __ __ __ __ __ __	

Information submitted must be legible, accurate and complete. Incomplete or illegible requests will be returned.

PRIMARY DIAGNOSIS:

ICD CODE	DESCRIPTION

CT OR PET* PROCEDURES			
DESCRIPTION	CPT CODE	DOS (from)	DOS (to)

Only non-emergent Computerized Tomography (CT) and Positron Emission Tomography (PET) for members between 21 and 64 years of age require prior authorization.

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MEDICAL NECESSITY DOCUMENTATION

Please attach electronic copies of supporting office notes, if applicable.

Why is this procedure necessary for this member? (Please include member's medical diagnosis and visit http://www.acr.org/Quality-Safety/Appropriateness-Criteria to review appropriateness criteria). Please be as specific as possible with regards to the clinical circumstances and include the duration and intensity of symptoms and purpose of the exam.

CLINICAL INDICATIONS:

Please check all that apply:

MRI/MRA OR ULTRASOUND PROCEDURES ARE CONTRAINDICATED FOR THIS PATIENT	☐ Yes	☐ No
IS THIS PROCEDURE TO EVALUATE CANCER STAGING?	☐ Yes	☐ No

ADDITIONAL CONSIDERATIONS:

Please explain any unique circumstances that are present that require this imaging modality at this time. Please include an explanation, if appropriate, as to why a procedure that is considered "more appropriate" per American College of Radiology Appropriateness Criteria (http://www.acr.org/Quality-Safety/Appropriateness-Criteria) was not selected.

CERTIFICATION

❑ **I have reviewed the ACR Appropriateness criteria for this request**

Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature*: _____ Date of Submission: _____

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***MUST MATCH THE REQUESTING PROVIDER LISTED ABOVE**

Instructions

1. Place an "X" next to the appropriate request type. *REQUIRED*
2. Enter the Electronic PA# if submitting an update to a PA or Supporting documentation. *SITUATIONAL*
3. Enter the Member Name, Date of Birth, and MaineCare ID #. *REQUIRED*
4. Enter Requesting Provider's Name, 10 digit NPI, and the 10 digit Group NPI (Pay-to). *REQUIRED*
5. Enter Requesting Provider's address. *REQUIRED*
6. Enter the Servicing Provider's name and 10 digit NPI. *REQUIRED*
7. Enter the primary diagnosis for the PA. For dates of services prior to 10/01/2015, use the appropriate ICD-9 code. For dates of service 10/01/2015 and forward, use the appropriate ICD-10 code. *REQUIRED*
8. CT or PET Procedures: enter the CPT description and code. *REQUIRED*
    a. Enter the DOS (from) and (to). If unsure of when the procedure will be rendered, it is appropriate to enter date range. *REQUIRED*
9. Notate why the procedure is necessary for the member. Be as specific as possible with regards to the clinical circumstances and include the duration and intensity of symptoms and purpose of the exam. *REQUIRED*
10. Enter an 'X' in the appropriate "Yes" or "No" box for each question. *REQUIRED*
11. Enter additional considerations. Explain any unique circumstances that are present that require the procedure. *SITUATIONAL*
12. Place an "X" in the box to acknowledge you have reviewed the ACR Appropriateness Criteria. *REQUIRED*
13. Signature of the prescribing physician and submission date. *REQUIRED*

All items marked as REQUIRED or SITUATIONAL may be returned if not completed accurately. Please contact Provider Services for additional help in completing this form or on how to submit PAs electronically using the MIHMS Portal.

Supporting documentation may be uploaded to the Health PAS Portal (https://mainecare.maine.gov) even after the PA has been submitted. **If submitting documentation via fax, place this completed form on top of the attachment(s) for each request or supporting documents submission.**

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***Disclaimer**: A prior authorization number does not guarantee that the PA has been medically approved or that the service will be paid.*